RELIANT MEDICAL GROUP
Part of OptumCare®

**MOTOR VEHICLE ACCIDENT INSURANCE INFORMATION**

**PATIENT: _____ MRN: _____DOB: _____**

**Date of Injury _____Body Part Injured_____State _____**

1. **Auto Insurance Company (insurance of auto you were in at time of accident- Mass is a no fault state)**
   **(Not the Agency!):**

   **Name: _____**

   **Address: _____**

   **_____**

   **Phone number: _____**

2. **Claim Number** for ***CURRENT INJURY :*** **_____**

3. **Name of Claims Adjuster:_____**

When completed you may fax this form to _____ or mail to:

Reliant Medical Group
1 Street
Town, State Zip

Please call _____if you have questions

**Delay in providing this information may result in receiving bills for services provided.**